

MDR Tracking Number: M5-04-1387-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on January 16, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the 97545 WH-AP Work Hardenin/Conditioning-initial, 97545 WH-AP- Work Hardening/Conditioning each add hour, 97750-FC-Functional Cap Eval, 99361- conf by phys, and 99215-OV were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Division has determined that fees were the only fees involved in the medical dispute to be resolved. As the treatment listed above were not found to be medically necessary, reimbursement for dates of service from 05-14-03 to 06-24-03 is denied and the Division declines to issue an Order in this dispute.

This Decision is hereby issued this 31st day of March 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division

PR/pr

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

March 19, 2004

Re: IRO Case # M5-04-1387

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule 133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate.

For that purpose, ____ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, who is licensed by the State of Texas, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ____ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ____ reviewer who reviewed this case, based on the medical records provided, is as follows:

History

The patient injured his left knee and low back in ____ when he slipped and fell. He was treated with physical therapy and chiropractic treatment. Knee surgery was performed on 11/6/02. The patient was placed at MMI on 2/18/03. The patient's surgeon recommended a return to work with restrictions on 2/20/03. The patient changed his treating doctor on 4/2/03. An FCE was performed on 5/14/03. The patient underwent a work hardening program for six weeks. The patient had been off during this entire period.

Requested Service(s)

97545 WH-AP Work Hardening/Conditioning- initial, 97546 WH-AP- Work Hardening/Conditioning each add hour, 97750-FC-Func Cap Eval, 99361, conf by phys, 99215 OV 5/14/03-6/24/03

Decision

I agree with the carrier's decision to deny the requested services.

Rationale

The patient had received an adequate trial of chiropractic treatment prior to the dates in dispute. This treatment included post-operative rehabilitation for the left knee. Continued treatment for a lumbar sprain injury past eight weeks would not be medically necessary. The patient was placed at MMI on 2/18/03, but he continued to receive chiropractic treatment without documented relief of his symptoms or improved function. Based on the diagnosis and the objective data presented in the records provided for this review, treatment (including the disputed work hardening) exceeded medically accepted standards for treatment of the patient's injury.

The documentation provided lacks specific objective, quantifiable findings to support the treatment for the dates in dispute.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.